



TOWN OF ISLIP DEPARTMENT OF PARKS, RECREATION & CULTURAL AFFAIRS

50 IRISH LANE EAST ISLIP, NY 11730 PHONE (631) 224-5335 TTY (631) 224-5397 FAX (631) 224-5638

Angie M. Carpenter, Supervisor
Thomas Owens, Commissioner

Dear Parking Permit Applicant:

The Town of Islip is pleased to provide you with the application for a Disabled Parking Permit. Please follow all requirements, so there is no delay in processing your application.

IMPORTANT INFORMATION

- Your Physician must state if your disability is **Permanent** or **Temporary**: A prescription pad in conjunction with an application stating Permanent or Temporary disability must be submitted. **We can not issue any permits without this documentation. (Fax copies of application will NOT be accepted.)**
- Please be advised that **NO PERMIT** will be issued without a **copy of your NYS Driver's License, Non Driver's ID or any other form of Photo ID**. All documents **must match your current home address** that is on the application. If not, please provide another form of documentation, with your current TOI address mailed to you within the last 6 months (i.e. PSEG, phone bill, car ins., car reg., etc.) along with your Photo ID. (P.O. Boxes need two additional proofs of current TOI residency to be presented.)
- In addition, a copy of a **Power of Attorney and DL** will be needed for applicants 18 and older that are unable to sign on their own behalf.
- **Please Note:** Medical Certification may only be completed by a physician, podiatrist, nurse practitioner or physician assistant who are authorized by NYSVTL Section 404-A. A Podiatrist may only certify conditions that constitute a severe disability of the foot. **Medical certification cannot be certified by a chiropractor, physical therapist or nurse**. Signature stamps are not acceptable. Your physician must provide **an original signature** when certifying this application for a Disabled Parking Permit.
- **Expired Parking Permits MUST be returned.**

Special Notice & Caution: New York State Traffic Law states that this permit be used exclusively in a vehicle in which the person to whom it has been issued is being transported, and such permit shall not be transferable and shall be forfeited, if presented by any other person. Any abuse by any person, facility or agency to whom such a permit has been issued, shall be sufficient cause for revocation of said permit of any privilege, benefit, precedence or consideration granted pursuant to the issuance of such permit. 1 203-c (ii)

If your application is approved, you will receive a blue (permanent) or a red (temporary) plastic permit which is to be hung on your rear view mirror when parked. If you have any questions about the application, please call (631)224-5335 (voice) or (631) 224-5397 (TTY), or you can visit us at 50 Irish Lane, East Islip, NY 11730.

Thank you for your cooperation



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Disabled Parking Permit Application

Name _____ Date of Birth: _____ Sex: M _____ F _____
Last First M.I.
Home Address: _____
Address Town Zip
Home Phone: _____ Cell or Business Phone: _____

I certify that the above information and the statements contained herein are true. I further acknowledge that I have read and understood the conditions of the application and the disabled parking permit.

Signature of Person with Disability/Signature of Parent or Guardian (**Blue Ink Only**) _____ Date _____

*A copy of a **Power of Attorney and DL** will be needed for applicants 18 and older that are unable to sign on their own behalf.

MEDICAL CERTIFICATION

(PLEASE PRINT OR TYPE- DO NOT ABBREVIATE OR USE OFFICE CODES)

Name of (MD/DO/DPM/NP/PA/OD): _____ Professional License # _____

Address of (MD/DO/DPM/NP/PA/OD): _____ Telephone # _____

Diagnosis: _____

☐ **TEMPORARY DISABILITY:** A person with a temporary disability is any person who is temporarily unable to ambulate without the aid of an assisting device. Examples of an assisting device include, but are not limited to, a brace, cane, crutch, prosthetic device, another person, wheelchair or walker. **TEMPORARY DISABILITIES**, however, may be certified only by a Medical Doctor or Doctor of Osteopathic Medicine. **IMPORTANT:** Temporary permits are issued for six months or less regardless of expected recovery date.

Expected Recovery Date: ____/____/____

What assistive device is needed: _____

☐ **PERMANENT DISABILITY:** A "severely disabled person" is any person with one or more of the PERMANENT impairments, disabilities or conditions listed below, which limit mobility. **PERMANENT DISABILITIES** may be certified by a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), a Doctor of Podiatric Medicine (DPM, for disabilities related to the foot) or Optometrist (OD, for blindness).

☐ Neuromuscular dysfunction that severely limits mobility Class III or IV cardiac condition (American Heart Assoc. Standards) ☐ Legally blind

☐ Severely limited in ability to walk due to an arthritic, neurological or orthopedic condition ☐ Limited or no use of one or both legs

☐ Restricted by lung disease to such an extent that forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than sixty mm/hg of room air at rest ☐ Unable to walk 200 ft. without stopping

☐ Has a physical or mental impairment or condition not listed above which constitutes an equal degree of disability, and which imposes unusual hardship in the use of public transportation and prevents the person from getting around without great difficulty ☐ Uses portable oxygen

Signature of (MD/DO/DPM/NP/PA/OD **ONLY**) (**Blue Ink Only. Signature Stamp not Acceptable**) _____ Date _____

For office use only:

Diagnosis Code: _____

New	Renewal	Second Tag	Temp-to-Perm	Damaged Tag
Permit #:	_____	Exp. Date: _____	Driver's License #:	_____
Prior #:	_____	Returned: _____	License Exp. Date:	_____
BAS:	_____		Disabled License Plate#:	_____